DEPARTMENT OF SOCIAL AND HEALTH SERVICES

THE CHILDREN'S ADMINISTRATION CENTRAL CASE REVIEW

FY2010
Division of Licensed Resources, Child Protective Service (DLR/CPS) Investigations Braam Settlement Agreement Benchmark Report

Washington State Department of Social & Health Services
CA Children's Administration

The Children's Administration is committed to ongoing quality assurance activities as part of a proactive process to assist social workers, supervisors and managers to improve outcomes for children and families.

Children's Administration

Central Case Review

Timeliness and Quality of Division of Licensed Resources Child Protective Service (DLR/CPS) Investigations Braam Benchmark Report for Fiscal Year 2010

I. Introduction

This report measures compliance with one benchmark from the July 2008 Revised Implementation Plan:

Unsafe /Inappropriate Placements, Goal 2, Outcome 2
All referrals alleging child abuse and neglect of children in out of home care will receive thorough investigation by the Division of licensing Resources (DLR) pursuant to CA policy and timeframe and with required documentation.

This report provides background information for this annual review and a summary of the review process, the sampling methodology, performance data by state and region, practice trends, and recommendations. Included as an appendix is the case review criteria used and applied. An additional appendix is provided to DLR leadership that provides case identifying information to help inform their practice improvement work.

II. Background and Purpose

The fourth case review of DLR/CPS investigations was conducted by the Children's Administration Central Case Review Team in January 2011 for fiscal year 2010 (FY10). The first two reviews included four questions related to the quality of the DLR/CPS investigation and addressing all serious and immediate safety concerns for the child. In the compliance plan submitted by CA in April 2009 in response to the Braam Oversight Panel's Monitoring Report #6, and approved by the Oversight Panel in June 2009, it was agreed that the case review for FY09 and subsequent years would look at two additional items:

- Was there an initial response (as measured by the initial face-to-face with the alleged victims) to the referral/intake within required timeframes (24 or 72 hours)?

- Was the investigation closed within 90 days? If not, did the extension of the investigation meet the exceptions allowed by statute and policy? How did the case meet the exception to the extension of the closing of the investigation (i.e., to collaborate with a law enforcement investigation).

The second of the above two questions was added to the case review due to a change in Washington State law. RCW 26.44.030(11)(a) went into effect on October 1, 2008 and requires that CPS investigations, including DLR/CPS investigations, be closed within 90 days in most circumstances:

> *For reports of alleged abuse or neglect that are accepted for investigation by the department, the investigation shall be conducted within time frames established by the department in rule. In no case shall the investigation extend longer than ninety days from the date the report is received, unless the investigation is being conducted under a written protocol pursuant to RCW 26.44.180 and a law enforcement agency or prosecuting attorney has determined that a longer investigation period is necessary.*

The original four case review questions that were approved by the Braam Panel in October 2007 and the two new questions approved in December 2009 are located in the Appendix of this report.

III. Review Process

A random sample of cases from each region was reviewed. The DLR/CPS case review involved a review of the following records: DLR/CPS intakes, case notes, provider notes, and Investigative Assessments.

IV. Sample Methodology

Agreement was reached between CA and the Braam Oversight Panel that the case review sample would include investigations involving homes and facilities with a child placed in the home/facility who was a member of the Braam Class. Investigations of day care facilities and homes or facilities that did not have a child in the Braam Class in the facility were excluded from the sample.

A random sample of cases was obtained from FamLink of investigations completed during FY10. The total number of completed investigations in FY10 was 891. A stratified sampling methodology at the 95% statewide confidence level was approved by the Braam Oversight Panel. The stratified sampling methodology ensured that the number of intakes/referrals reviewed from each of the six CA regions closely approximated their representation in the population of completed investigations for FY10. The number of intakes and corresponding investigations reviewed for this report was 269.

It should be noted that prior to this review the Panel agreed to allow CA to adjust the case review methodology to allow the case review team to make adjustments if the DLR/CPS case had been incorrectly screened in for investigation, or if subjects and/or victims had been incorrectly identified. These changes were reviewed by the deputy DLR administrator.

Table 1

DLR/CPS Case Sample							
	State Total	**Region 1**	**Region 2**	**Region 3**	**Region 4**	**Region 5**	**Region 6**
Total # of Investigations FY 2010	891	179	112	106	166	166	162
Stratified Sample Percent	100%	20.07%	12.56%	11.90%	18.61%	18.61%	18.16%
# of Intakes Reviewed	**269**	**54**	**34**	**32**	**50**	**50**	**49**

Table 2

Types of Facilities Included in the Review							
	State Total	**Region 1**	**Region 2**	**Region 3**	**Region 4**	**Region 5**	**Region 6**
Foster Homes	220	46	33	20	34	42	45
Group Homes	41	8	-	11	16	3	3
State Operated/ Certified Facilities	7	-	1	-	-	5	1
Unlicensed Homes & Closed Foster Homes	1	-	-	1	-	-	-
Total Number of Intakes Reviewed	**269**	**54**	**34**	**32**	**50**	**50**	**49**

The types of facilities subject to this review included the following groups:

1. **Foster home and adoptive home:** This included the following types of homes if there was child placed by Children's Administration in the home:
   - Foster homes licensed by CA
   - Foster homes licensed by Child Placing Agencies
   - Homes currently certified by CA as a potential adoptive placement

2. **Group home:** This included any of the following types of facilities if there was a child placed by Children's Administration in the facility or supervised by agency staff.
   - Group homes
   - Staffed residential homes
   - Group receiving home
   - Emergency respite center
   - Overnight youth shelters
   - Crisis residential centers
   - Child placing agency staff

3. **State operated/certified facilities providing 24 hour care:** This included facilities operated by one of the following DSHS agencies if there was a child placed by CA or a child in the Braam Class living in the facility:
   - Division of Alcohol and Substance Abuse (DASA)
   - Division of Developmental Disabilities (DDD)
   - Juvenile Rehabilitation Administration (JRA)
   - Mental Health Division (MHD)
   - Washington State School for the Deaf
   - Washington State School for the Blind

4. **Unlicensed homes and closed foster homes:** This included the following types of homes if there was a child placed by Children's Administration in the home:
   - Homes with a pending initial foster home license
   - Unlicensed homes

V. Results

A. Benchmark Compliance by State and Region[1]

Benchmark	**Goal 2, Outcome 2** **Percentage of referrals/intakes alleging child abuse and neglect of children in out-of-home care receiving thorough investigation by the Division of Licensed Resources, pursuant to CA policy and timeline, and with required documentation will be 100% by region and the state as a whole.**

	FY07	FY08	FY09	FY10
100%	**87.0%** *(200 out of 230)*	**90.9%** *(210 out of 231)*	**82.9%** *(218 out of 263)*	**90.3%** *(243 out of 269)*

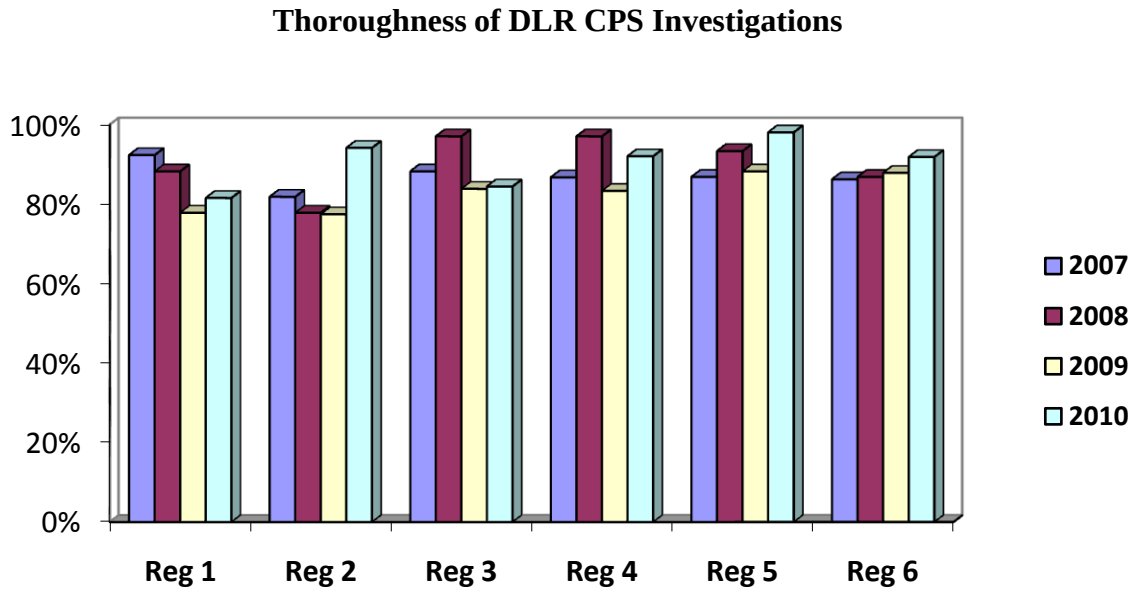
Data for FY07-FY08 are not comparable to data for FY09-FY10. Prior to FY09, the benchmark results were based on four case review questions that examined the thoroughness of DLR/CPS investigations. Beginning with FY09, the case review continued to examine thoroughness, and two new questions were added to the benchmark results to examine the timeliness of initial response to the intake and of the closure of the investigation.

Benchmark	**D 2.2.1 Percentage of intakes alleging child abuse and neglect of children in out-of-home care receiving thorough investigation by the Division of Licensed Resources (DLR), pursuant to CA policy and timeline with required documentation will be 100% by region and the state as a whole.**

	Statewide	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
% Compliance	**90.3%** *(243 out of 269)*	81.5% *(44 out of 54)*	94.1% *(32 out of 34)*	84.4% *(27 out of 32)*	92% *(46 out of 50)*	98% *(49 out of 50)*	91.8% *(45 out of 49)*

[1] The statewide compliance rate for FY2010 (90.3%) is 7.4% higher than the rate for F09 (82.9%). FY09 was the first year that included six questions in the case review.

B. Regional Benchmark Compliance FY07 through FY10



C. Results by Facility Type

Statewide Results By Facility Type				
	Foster Homes	**Group Homes**	**State Operated/Certified Facilities**	**Unlicensed Homes & Closed Foster Homes**
% Compliance	90% *(199 out of 220)*	85% *(35 out of 41)*	100%	100%
Total Applicable Cases	220	41	7	1

D. Case Review Questions

Six questions were developed to evaluate the timeliness of investigations, thoroughness of the investigations, safety assessments, and safety planning. Each question was given equal weight. Compliance with the benchmark was achieved when each of the six questions were rated Fully Achieved or Not Applicable. The decision rules for rating each of the questions are located in the Appendix of this report.

Question 1	**Was an initial face to face (IFF) contact made with all alleged child victims within required timeframes?**						
	Statewide	**Region 1**	**Region 2**	**Region 3**	**Region 4**	**Region 5**	**Region 6**
Full Compliance	**91.4%**	87%	82.4%	90.6%	92%	98%	95.9%
Total Applicable Intakes	**269** *(246 out of 269)*	54 *(47 out of 54)*	34 *(28 out of 34)*	32 *(29 out of 32)*	50 *(46 out of 50)*	50 *(49 out of 50)*	49 *(47 out of 49)*

246 out of 269 cases were rated Fully Compliant

- In some cases, there had been a time limited extension entered in FamLink for the initial face to face contact that was not supported by either CA policy, or by the case file documentation. The majority of these had extensions citing coordination with law enforcement as the reason for not meeting the time frames. However, there was no documentation found that law enforcement coordination occurred.
- In some cases, a time limited extension for the initial face to face contact was warranted and supported by policy. However, there was no documentation of subsequent efforts to locate and initiate face to face contact with the alleged child victim as soon as possible. In a few cases, law enforcement was initially involved but then closed their case or gave permission for CA to continue with interviews and alleged victims were not interviewed timely.
- In one case, the initial face to face contact was conducted by the alleged victim's DCFS social worker and there was no subsequent follow up or attempt to interview the alleged victim by the DLR/CPS investigator.
- In one case, there was approximately a one week delay because the intake had not been received by the DLR/CPS supervisor timely.

Question 2	Were all suspected victims of alleged child abuse or neglect (CA/N) interviewed?						
	Statewide	**Region 1**	**Region 2**	**Region 3**	**Region 4**	**Region 5**	**Region 6**
Full Compliance	**99.6%**	98.1%	100%	100%	100%	100%	100%
Total Applicable Intakes	**268**	53	34	32	50	50	49

267 out of 268 referrals were rated Fully Compliant

- In the one case rated non compliant, the alleged victim was seen face to face by the assigned DCFS social worker for a health and safety visit one day prior to the receipt of the intake. While the DCFS social worker documented the bruising to the child that was the basis of the intake, there was no follow up face to face contact with the alleged victim made by DLR/CPS for the purpose of assessing risk and safety threats.

Question 3	Were all subjects interviewed?						
	Statewide	**Region 1**	**Region 2**	**Region 3**	**Region 4**	**Region 5**	**Region 6**
Full Compliance	**98.5%**	92.6%	100%	100%	100%	100%	100%
Total Applicable Intakes	**269**	54	34	32	50	50	49

265 out of 269 cases were rated Fully Compliant

- Two of the cases rated non compliant involved the same foster home. In both investigations, the foster mother and foster father were identified as alleged subjects of CA/N and only the foster mother was interviewed about the allegations. In these cases, the foster fathers were identified as either witnessing or having knowledge of the circumstances described in the allegations.
- In the other two cases rated non compliant, while the foster mother was identified in the intake as the alleged subject, it was reasonable that the foster father should also have been identified as an alleged subject and interviewed as the allegations involved unexplained bruising/injury of a foster child. The foster father was not interviewed in either case.

Question 4	Was adequate information gathered during the investigation to assess child safety?						
	Statewide	**Region 1**	**Region 2**	**Region 3**	**Region 4**	**Region 5**	**Region 6**
Full Compliance	**91.1%**	85.2%	94.1%	84.4%	92%	98%	91.8%
Total Applicable Intakes	**269** *(246 out of 269)*	54 *(46 out of 54)*	34 *(32 out of 34)*	32 *(27 out of 32)*	50 *(46 out of 50)*	50 *(49 out of 50)*	49 *(45 out of 49)*

245 out of 269 cases were rated Fully Compliant

- In some cases rated non compliant, the interview with the alleged victim(s) was not comprehensive and did not provide enough information to assess child safety. There were several cases where the victims were observed and there was a physical description of the victims documented but no attempts to interview them.
- In several cases rated non compliant, the subject interviews were not comprehensive and did not provide enough information to assess child safety.
- In some cases rated non compliant, there were other children (biological or foster) who resided in the home at the time of the alleged incident. These children, who were not identified as victims, may have been possible witnesses to the alleged incident and/or could have provided additional information in assessing child safety and risk. There was no documentation of attempts to interview these children as collaterals.
- In several other cases rated non compliant, there were other collateral contacts that could have been made and were not. These included contacts with a program director, foster father, DCFS social worker, or other adults who either lived in the home/facility, and/or were reportedly present at the time of the alleged incidents. In these cases, it was determined that additional information from the collateral sources could have provided additional information in assessing child safety and risk.

Question 5	If child safety threats existed, were appropriate actions taken to ensure the safety of the child(ren)?						
	Statewide	**Region 1**	**Region 2**	**Region 3**	**Region 4**	**Region 5**	**Region 6**
Full Compliance	**100%**	100%	100%	100%	100%	100%	100%
Total Applicable Intakes	**66**	17	12	11	11	6	9

Safety threats were defined as conditions in which a child was at risk of serious and immediate harm. Consequently, if no safety threats existed in the investigation, this question was rated as Not Applicable. Safety threats existed in 66 of the 269 cases reviewed and appropriate actions (e.g. moving a child from an unsafe placement, requiring the implementation of a safety plan, etc.) were taken to ensure safety of the children.

Question 6	Was the investigation closed within 90 days?						
	Statewide	**Region 1**	**Region 2**	**Region 3**	**Region 4**	**Region 5**	**Region 6**
Full Compliance	**98.1%**	94.4%	97.1%	96.9%	100%	100%	100%
Total Applicable Intakes	**269** *(264 out of 269)*	54 *(51 out of 54)*	34 *(33 out of 34)*	32 *(31 out of 32)*	50	50	49

<u>264 out of 269 cases were rated Fully Compliant</u>

- There were 14 cases with extensions that met the exceptions allowed by statute and policy. These cases were open longer than 90 days because the prosecuting attorney and/or law enforcement were involved.

- There were five cases rated non compliance. In three of the five cases rated non compliant, the investigations were closed between 102 and 159 days of the intake. In the other two cases case rated non compliant, the investigations were closed at 258 and 348 days, respectively.

- In two of the five cases where there was delay in the completion of the investigation, there was no documentation as to the reason for the delay. In the remaining three cases, the following reasons were noted:

    1. In one case, while law enforcement was initially involved, they concluded their investigation within a few weeks of receipt of the intake and the delay in the conclusion of investigation was related to a failure by the investigator to make face to face contact with one of the identified alleged victims. The supervisor documented that the victim had been interviewed by law enforcement but that the investigator was not aware that he also needed to make face to face contact with the victim.
    2. In another case, a specific reason was not documented for the delay in the investigation. However, it appeared that law enforcement was initially involved, and that there were delays in making follow up face to face contact with the alleged victim by DLR after law enforcement closed their case.
    3. In the last case, the intake was connected to an Investigate Assessment that involved another intake on the facility that was received one day before where law enforcement was involved. Many of the case notes cited both intake numbers and it appeared that the investigator was citing law enforcement involvement as the reason for the delay in both investigations. However, law enforcement was only investigating the allegations in the earlier intake.

VI. Practice Trends

The practice trends identified below include trends resulting from the case review of the timeliness and the quality of investigations, as well as additional practice trends that were noted in the review.

1. Quality of Alleged Child Victim Interviews

   There were cases where concerns were noted regarding the circumstances related to the interview of the alleged victim(s) which may have impacted the quality of the interview including:

   - Alleged child victims were sometimes interviewed in the presence of other people including other children in the home/facility, siblings, biological parents, etc.
   - In some cases the alleged victims were interviewed in the foster home in close proximity to the foster parents (within earshot) who were also identified as alleged subjects and it was unclear why attempts had not been made to interview the victims at school or another location away from the home.
   - There were also some cases where it appeared that the alleged subjects were informed of the allegations prior to the victim being interviewed.
   - There were cases where the foster parents were asked permission and notified prior to DLR/CPS interviewing the foster parents' children in spite of those children having been identified as alleged victims.

2. Dating the Initial Face to Face (IFF) with Alleged Victims Using a Contact Date with the Child Prior to the Date of the Intake

   There were some cases where during the course of a DLR/CPS investigation, the investigator learned of new allegations while interviewing alleged victims or collaterals. After the investigator made an intake with the new allegations, there were occasions where the investigator used the original IFF to meet the face-to-face requirement for the new intake.

   There were some cases in which the assigned social worker for the child made the intake after the child reported CA/N during a health and safety visit. The DLR/CPS investigator used the contact made by the assigned social worker during the health and safety visit to meet the requirement for the initial face to face (IFF) contact for the new intake.

3. Subject Interviews

   There were cases where it did not appear that the alleged subject was offered the opportunity for a face-to-face interview and the interview instead occurred by phone. Also in some of these cases, since the interview with the alleged subject occurred by

phone, there was no on site visit to the facility or foster home during the course of the investigation.

There were also cases where the case notes indicated that the subject requested to be interviewed by phone. In some of these cases, there was also no on site visit to the facility or foster home during the course of the investigation

4. Audio Recording

There were cases where there appeared to be no attempts to audio record interviews of alleged child victims when there were allegations of sexual abuse and/or physical abuse.

5. Meeting the 24 or 72 hour Initial Face to Face (IFF) Requirement and Use of Supervisory Extensions

The main practice trends that were identified in cases where the IFF contact was not completed within the required timeframes involved:

- There were inconsistencies in the use of extensions particularly related to law enforcement coordination. In some cases an extension was entered for coordination with law enforcement but there was no documentation of coordination found beyond the intake being faxed to the local law enforcement agency within the 24/72 hour investigative timeframes.
- In some cases, the initial extension was warranted and supported by the documentation (law enforcement may have initially accepted the case or asked DLR to hold off on interviewing the alleged victims) but once law enforcement advised DLR/CPS to proceed with their investigation there was a delay in efforts to initiate face to face contact with the alleged child victim as soon as was possible.
- There were also some cases where an extension was entered because the alleged child victim was unable to be located within the timeframes but then there were no efforts thereafter to initiate face to face contact with the alleged child victim as soon as was possible.
- There were some cases that did not include timely IFF with all victims on cases with multiple alleged victims.

6. Accurate Identification of Alleged Subjects

In some cases the information received at the time of the intake was not comprehensive enough to identify which foster parents were present when the alleged incident of CA/N occurred to determine who should be identified as the alleged subject. Frequently, the foster mother was identified by intake as the sole alleged subject. As a result, there were investigations were the foster fathers were not interviewed even though they may have also been present and should have also been a subject. In addition, they were also not interviewed as a collateral contact.

VI. Recommendations

The following recommendations are developed to address the primary practice trends for cases that were not compliant:

1. **DLR/CPS staff be provided in-service training to review and address policy and practice expectations for investigations.**

2. **DLR Leadership in collaboration with staff develop and implement a quality assurance process to increase Area Administrator (AA) and supervisory oversight.**

   The QA Plan should address the following improvement needs and recommendations:

   A. Increase the timeliness and quality of Initial Face to Face (IFF) contacts with alleged victims of child abuse and neglect (CA/N).

   - Ongoing and increased oversight by the Area Administrator regarding the quality of investigative interviews with child victims, the appropriateness of extension approved by supervisors, and timely IFF follow up.
   - Timely supervisory oversight occur and be documented in FamLink

   B. Increase the accuracy of identifying alleged subjects.

   - Supervisory review occur at the time of Intake assignment to ensure that all alleged subjects are correctly identified in FamLink based on the information known as to who was present when the incident occurred.
   - Ongoing supervisory oversight occur during monthly supervisory reviews to ensure additional alleged subjects are interviewed when there is new information gathered indicating that there were additional caregivers present when the alleged incident occurred.

   C. Ensure that all subject interviews occur in-person and there is an on-site visit in each investigation.

   - Supervisors review documentation to ensure: (a) all subject interviews occurred in-person, or (b) an in-person interview was offered but the subject refused therefore the interview occurred by phone.
   - Supervisors review documentation to ensure: An on-site visit occurred during the course of the investigation when the subject was interviewed away from the facility or on the phone.
   - If the subject refuses to allow the DLR/CPS investigator to enter the facility, the DLR/CPS investigator immediately contacts their supervisor and the licensor for the facility, and document the information in a case note.

VII. Appendix: DLR/CPS Case Review Questions and Decision Rules

1. Was an initial face to face (IFF) contact made will all alleged child victims within required timeframes?

Full Compliance: The IFF contact was made with all alleged child victims within the required 24 or 72 hour response time, ***or***
There was a child safety concern or inability to locate the child victim(s) that required a time limited extension or exception to the 24 or 72 hour face to face requirement that is supported in policy. These include:

Extensions:

1. When protocols with law enforcement or other community resources (e.g. sexual assault clinics) exist that require CA to delay seeing the child or contacting parents in order to assign specialists, or to coordinate the investigation.

2. When a child is unable to be located within the 24 or 72 hour timeframe after diligent efforts to locate the child. The DLR/CPS investigator shall continue to make efforts to locate and initiate face-to face contact with the alleged victim as soon as possible.

3. When a child is placed in protective custody and transported to another licensed facility (foster home, group care, CRC, crisis nursery, etc.) by law enforcement and the immediate safety issues for that child are addressed. A DLR/CPS investigator shall have face to face contact with the child by the end of the next business day.

4. When a child is placed on a hospital hold, or in protective custody that does not allow the child to leave the hospital, and the immediate safety issues for that child are addressed. A DLR/CPS investigator shall have face to face contact with the child by the end of the next business day.

5. In situations where a child's safety may be compromised by conducting the initial face to face contact within 24 hours, the Area Administrator may approve a time-limited extension.

6. In cases where an intake relates to the alleged abuse or neglect of a child in an out-of-home placement and the victim(s) of emergent DLR/CPS referrals are no longer in the facility. The DLR/CPS investigator shall have face to face contact with the alleged child victim(s) within the 72 hour timeframe. The

DLR/CPS investigator shall have face to face contact with children who have not been identified as victims who are in the facility and may be at risk of imminent harm within 24 hours from the date and time the referral is received by CA.

7. In cases where an intake relates to the alleged abuse or neglect of a child in a facility that is not providing care for children during the weekend or holiday, the face to face contact shall occur by the end of the next business day.

8. In custody cases where an intake relates to the alleged abuse or neglect of a child by one parent (subject) and the child is residing with the other parent, face to face contact with the child shall occur by the end of the next business day. Children who have not been identified as victims, who are in the care of the alleged abuser and who may be at risk of imminent harm, shall have face to face contact with a CA social worker within 24 hours from the date and time of the referral is received by CA.

9. In cases where an intake initially screens in to licensing and it is changed to DLR/CPS based on new information, the response time begins when the intake screens in for DLR/CPS.

Exceptions:

1. When a child cannot be located and diligent efforts have been made, or face to face contact cannot occur because the child is deceased or has moved out of state.

Non-Compliance: The IFF contact was not made with all alleged child victims within the required 24 or 72 hour response time, and there was not a time limited extension or exception to the required timeframe that is supported by policy.

NA: None

2. Were all suspected victims of alleged child abuse or neglect (CA/N) interviewed?

Full Compliance: All children were interviewed who were suspected victims of CA/N including the following:

- Suspected child victims that were identified at the time of the referral (they were coded as victims in the referral)
- Additional suspected child victims who were identified during the course of the investigation and were subsequently coded as victims
- Children who were not identified as suspected child victims but based on a review of the case should have been identified as victims,

and/or

The suspected child victim(s) was non-verbal, and a physical and behavioral description of the child(ren) including injuries (if applicable) was documented,

and/or

The child interview was unsuccessful because the suspected victims(s) refused to cooperate, and a physical and behavioral description of the child including a description of injuries was documented,

and/or

The whereabouts of the suspected child victim were not known, and efforts were made to locate the child.

Non-Compliance There were suspected child victims who were not interviewed,

and/or

The suspected child victim(s) was non-verbal, and a physical and behavioral description of the child(ren) including injuries (if applicable) was <u>not</u> documented,

and/or

The child interview was unsuccessful because the suspected victims(s) refused to cooperate, and a physical and behavioral description of the child including a description of injuries was <u>not</u> documented,

and/or

The whereabouts of the suspected child victim were not known, and efforts were <u>not</u> made to locate the child.

NA: Face to face contact with the suspected victim(s) could not occur because the victim was deceased or had moved out of state.

Factors to consider when determining if a child should be considered a suspected victim:

- *Was information gathered through interviews with suspected child victims, subjects, collateral contacts or witnesses that indicated other children in the subject's care may also have been victims of CA/N?*
- *Were there other children living in the facility at the time of the alleged CA/N who may also have been victimized?*
- *Were other suspected child victims identified by a review of records relevant to the investigation?*

3. Were all subjects interviewed?

Full Compliance: All subjects were interviewed including:

- Subjects identified at the time of the referral (they were coded as subjects in the referral)
- Additional subjects who were identified during the course of the investigation and were subsequently coded as subjects
- Subjects who were not identified as subjects but based on a review of the case should have been identified as subjects

and/or

All subjects were interviewed by LE according to local LE protocols and the DLR investigator offered all alleged subjects the opportunity for an interview,

or

All subjects were interviewed by LE according to LE protocols and the DLR investigator did not offer an interview to the subject(s) due to the request by LE,

and/or

Reasonable attempts were made to interview all alleged subjects, but the alleged subjects refused to cooperate.

Non-Compliance: There were subject(s) who were not interviewed and reasonable attempts were not made to locate or interview the subject(s).

NA: No subject was identified on the referral,

or

The subject(s) location was not known.

Factors to consider when determining if reasonable attempts were made to interview the subject:

- *If the subject's location was unknown, were attempts made to locate the subject through an inquiry with people likely to know the subjects current whereabouts?*
- *Were multiple attempts made to contact the subject at all known phone numbers and/or locations the subject was likely to be?*
- *Was a letter sent to the subject offering an interview?*
- *Was the subject contacted for an interview and refused to cooperate?*

4. Was adequate information gathered during the investigation to assess child safety?

Definitions from Practice Guide to Risk Assessment :

- *<u>Child safety</u> is a condition in which a child is protected from serious and immediate harm.*
- *<u>Serious and immediate harm</u> involves child abuse and neglect that could result in death, life endangering illness, injury requiring medical attention, traumatic emotional harm or severe developmental harm that has severe lasting effects on the child's well being.*

Fully Achieved: Adequate information was gathered during the investigation to adequately assess child safety through the following investigative activities when applicable:

- Child interviews
- Subject interviews
- Collateral contacts
- Witness contacts
- Review of records

Not Achieved: Adequate information was not gathered during the investigation to assess child safety.

NA: None

Factors to consider when determining if adequate information was gathered:

- *Were all suspected child victims interviewed?*
- *Did child interviews address all allegations and safety concerns?*
- *Were all subjects interviewed?*
- *Did subject interviews address all allegations and safety concerns?*
- *If information in the referral was unclear, was the referent contacted to clarify the intake information?*
- *If the allegation of CA/N indicated a possible crime was committed, was law enforcement contacted for coordination?*
- *Were there professionals in the subject's or child's life who may shed light on the matter under investigation and/or may provide pertinent history? Were they contacted or an attempt made? (collateral sources may be medical providers, therapists, school personnel, and/or the child's social worker)*
- *Were there witnesses to the incident under investigation? Were they contacted or an attempt made? (witnesses may include other children in the home, other staff, or others with knowledge of the incident)*
- *Were records reviewed that may have shed light on the matter under investigation?(facility investigations records may include: logs, child records, personnel records, training records, attendance records and/or licensing records)*

- *Was an on-site visit made to the facility during the course of the investigation to evaluate the current condition and environment of the suspected child victims to determine health and safety risks?*
- *Was consultation from other professionals including physicians or psychologists sought? This would include medical consultation to assist in determining the origin of a child's injuries.*
- *Was the pattern of prior complaints considered when assessing safety?*

5. If child safety threats existed, were appropriate actions taken to ensure the safety of the child(ren)?

Definitions from Practice Guide to Risk Assessment:

- *Safety threats involve conditions in which a child is at risk of serious and immediate harm*
- *Serious and immediate harm involves child abuse and neglect that could result in death, life endangering illness, injury requiring medical attention, traumatic emotional harm or severe developmental harm that has severe lasting effects on the child's well being.*
- *Safety planning protects the child from serious and immediate harm by concrete steps and immediate action that addresses the danger or threat.*

Fully Achieved: Safety threats for the child(ren) existed and appropriate action was taken to ensure the protection of the child(ren) which may include the following:

- Safety planning occurred that addressed the safety concerns (e.g. the alleged subject/perpetrator was asked to leave the facility pending the investigation)
- Removal of the child from the facility

Not Achieved: Safety threats existed for the child(ren) and appropriate actions were not taken to ensure the protection of the child.

NA: Child safety threats did not exist,

or

The home addressed all child safety threats before the department was involved.

Factors to consider when determining if appropriate actions were made:

- *If there was safety planning, was it developed within a time frame that ensured the immediate safety of the child?*
- *Was the safety planning effective by:*
    1. *Focusing on the child's safety needs*
    2. *Increasing the child's visibility*
    3. *Including a number of parties who share the role of assuring child safety*
    4. *Being realistic and achievable*
    5. *Being developed in consultation with the caregiver*
    6. *Being specific, detailed and containing timelines for completion*
    7. *Identifying the roles and responsibilities of various adults in helping keep the child safe*
- *Did the safety plan require monitoring beyond the closure of the investigation? If needed, was there a plan for monitoring?*

6. Was the Investigation closed within 90 days?

Full Compliance: The Investigative Assessment was completed and approved by the supervisor within 90 days of the date of the intake, ***or***
The case was open beyond 90 days due to continued involvement with law enforcement or the prosecuting attorney.

Non-Compliance: The Investigative Assessment was not completed and approved by the supervisor within 90 days of the date of the intake and there was not continued involvement with law enforcement or the prosecuting attorney.

NA: The investigation was closed prior to October 1, 2008 when the statue became effective.

Rules Used to Assess Compliance

If questions #1 through #6 are "Fully Compliant" or "Not Applicable" the case is compliant.